STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 12, 13, 14, and 15, 2011 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Survey team: Toni Maley, BSW, TC Tammy Alley, RN Donna Smith, RN Census bed type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 16 Medicaid: 69 Other: 16 Total: 101 Sample: 21 Supplemental: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction is the centers Allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provision of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 9/22/11 Cathy Emswiller RN			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for verbal abuse in a sample of 21 (Resident #49). Findings Including: 1.) Resident #49's clinical record was reviewed on 9/12/11 at 10:50 a.m. Resident #49's diagnoses included, but were not limited to, congestive heart failure and hypertension. Resident #49 had a current, 7/6/11, Minimum Data Set assessment, which indicated the resident was had no cognitive impairment, was able to make wants and needs know and needed staff assistance to dress. 2.) Review of a 9/2/11, "Facility Incident	F0223	This Plan of Correction is the centers Allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provision of federal and state law.A. Resident #49 ws assessed, no injuries were identified.The Executive Director, DNS, primary physician and responsible parties were notified immediately. An abuse investigation was initiated immediately; staff involved was removed from service pending the outcome of a comprehensive investigation.Staff members recieved re-education to the Abuse, Neglect and Exploitation standard of the facility.B. Alert and oriented residents within the facility have been interviewed to determine if any other allegations	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Reporting Form" indicated the following: On 9/2/11 at 8:30 p.m., Resident #49 asked for assistant to change her nightgown. CNA #1 told the resident she could do it herself. Resident #49 asked CNA #1 a second time for assistance. CNA #1 again refused and told the resident to do it herself. The resident informed the CNA she intended to report her refusal to the Administrator. CNA #1 responded by yelling at the resident "You are being mean and hateful!" CNA #1 was then heard telling the resident not to use her call light again. The report indicated an investigation was completed and CNA #1 was terminated. 3.) During a 9/14/11, 1:40 p.m. interview, Resident #49 indicated she felt the facility took prompt action following her altercation with CNA #1 and she was satisfied with the facilities response. 4.) The facility followed it's policy and procedure for the investigation of verbal abuse, which included but was not limited to: a.) All reviewed employees, including CNA #1, had criminal history checks and reference checks at the time of hire. b.) All reviewed employees, including		were identified. No other residents were affected.C. A comprehensive in-service was conducted facility wide to re-educate staff members on acceptable approaches for residents who may require assistance.The facility abuse, neglect and exploitation standard and guideline have been re-inserviced assuring staff members are aware of their responsibility to intervene immediately and report alleged or actual abuse, neglect, or exploitation.D. The DNS, SSD and or designee will randomly interview 3 residents weekly for 6 months, then 1 resident weekly for 6 months to total 12 months of monitoring, to determine if any allegations of abuse exist and report concerns immediately to the Executive Director\DNS for investigating and reporting according to Facility, State, and Federal guidelines.Any identified issues will be immediately corrected and investigated per required regulatory standards.Identified concerns as well as resident council meeting minutes will be reported to the monthly Performance Improvement team to determine continued compliance.E 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #1, received abuse prohibition training at the time of hire and annually or more frequently. c.) CNA #1 was immediately suspended following the allegation of abuse and terminated following the substantiation of abuse. d.) Resident safety was maintained during the investigation process. e.) Additional residents were interviewed to ensure other residents had not been negatively impacted by this even or like events. f.) Current facility personnel were re-inserviced regarding the facility abuse prohibition policy following the event. g.) Applicable state agencies were notified of the event, investigation and outcome. 4.) A review of the current, undated, facility policy titled "Abuse Prevention", which was provided by the Administrator on 9/12/11 at 3:30 p.m., indicated the following: "Verbal abuse-Any use of oral, written or gestured language that is disparaging or derogatory to residents or used to describe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents, regardless of the resident's age, ability to comprehend or mental and/or physical disability." 3.1-27(b)			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure dependent residents were fed in a manner to preserve their dignity, dependent residents did not wait extended periods of time without receiving a meal tray, and resident in need of cleaning following an incontinent episode were cleans in a manner which allowed them to feel clean for 6 of 21 residents reviewed for preservation of dignity in a sample of 21 (Residents #63, #29, #67, #70, #25, & #13) and 1 of 1 resident reviewed for preservation of dignity in a supplemental sample of 2 (Resident #69). Finding include: 1.) Resident #63's clinical record was reviewed on 9/14/11 at 10:30 a.m. Resident #63's current diagnoses included, but were not limited to, Alzheimer's	F0241	A. Resident's #63, #70, #25, #69,#67 and #29 were assessed and assistance was provided to encourage meal intake. Care plans were reviewed and revised as appropriate.Direct care staff was inserviced on providing assistance with dining in a manner that provides dignity, nutrition and social interaction.Feeding ratio will be 1 staff to 2 residents per table.Indentified residents recieved meals at appropriate temperatures.Cook #9 was immediately inserviced on scoop portions and dining procedures. Dietary staff was inserviced on appropriate scoop portions, food temps, and dining procedures. Licensed staff will notify dietary when dining room residents have all been served to ensure that assistance is provided to those residents that require it.Resident #13 no longer resident within the facility.Therapy staff #3 was immediately educated on the requirements related to provision	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disease and hypertension. Resident #63 had a current, 6/23/11, quarterly, Minimum Data Set assessment which indicated the resident required staff assistance to eat and had cognitive impairment and required cueing and prompting for decision making. Resident #63 had a current, 6/11, care plan problem regarding the potential for weight loss. An approach to this problem was to provided assistance at meal to encourage intake. 2.) Resident #70's clinical record was reviewed on 9/14/11 at 10:10 a.m. Resident #70's current diagnoses included, but were not limited to, delusional disorder, mental retardation and cerebral palsy. Resident #70 had a current, 8/2/11, annual, Minimum Data Set assessment which indicated the resident required staff assistance to eat and had cognitive impairment and required cueing and prompting for decision making. Resident #70 had a current, 8/11, care plan problem regarding nutrition risk. An approach to this problem was to ensure		of incontinent care.B. Any residents that require assistance with feeding had the potential to be affected; however no negative outcome was identified.Audit was completed to identify those residents that are currrently incontinent and require assistance with personal hygiene. Those resident identified to be incontinent have had their care plans reviewed and revised to reflect appropriate care.C.N.A assignment sheets were updated to reflect those residents that require incontinent care.C. Direct care staff was inserviced on providing assistance with dining in a manner that provided dignity, nutrition and social interaction.Dietary staff was inserviced on scoop portions, food temps and dining room procedures.Direct care staff and therapy was educated on the components of F241 regarding the provision of providing dignity when performing incontinent care and personal hygiene.Systematic changes include observation of incontinent/personal hygiene three times weekly to include all three shifts.Management supervison/Dining Room Facilitator will be provided during all three meals to determine that assistance is provided to those residents that require it.D. The monitoring of this tag will be the joint effort of the Executive Director/DNS/Designee.Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	adequate intake. 3.) Resident #25's clinical record was reviewed on 9/14/11 at 9:20 a.m. Resident #25's current diagnoses included, but were not limited to, Alzheimer's disease and depression. Resident #25 had a current, 8/9/11, quarterly, Minimum Data Set assessment which indicated the resident required staff assistance to eat and had cognitive impairment and rarely or never made decisions. Resident #25 had a current,8/11, care plan problem regarding nutritional risk. An approach to this problem was to provide assistance to ensure adequate intake. 4.) Resident #69's clinical record was reviewed on 9/14/11 at 10:40 a.m. Resident #69's current diagnoses included, but were not limited to, vascular dementia and anxiety. Resident #69 had a current, 8/3/11, quarterly, Minimum Data Set assessment which indicated the resident required staff assistance to eat and had cognitive		Director/Designee will randomly audit one meal five times weekly for accurate scoop sizes, food temps and dining room service.Audits will continue for six months then decrease to three meals for six months to total twelve months of auditing. DNS/designee will complete observational audit on incontinent/personel hygiene care weekly for six months then one time weekly for six months to total twelve months of auditing.Results of auditing will be taken to the monthly Performance Improvement Management meeting until substantial compliance is achieved and or the committee recommends discontinuation of monthly reporting.E. 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	impairment and required cueing and prompting for decision making. Resident #69 had a current,8/3/11, care plan problem regarding nutritional risk. An approach to this problem was to provide assistance to ensure adequate intake. 5.) Resident #67's clinical record was reviewed on 9/14/11 at 10:50 a.m. Resident #67's current diagnoses included, but were not limited to, schizophrenia and hypertension. Resident #67 had a current,7/1/11, quarterly, Minimum Data Set assessment which indicated the resident rarely or never made decisions. Resident #67 had a current, 7/11, care plan problem regarding nutritional risk. An approach to this problem was to provide a diet as ordered. Resident #67 had a current 7/11 care plan problem which indicated the resident has "incoherent speech, resident often will not be able to make full sentence or will not ask question coherently." 6.)Resident #29's clinical record was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 9/14/11 at 9:30 a.m. Resident #29's current diagnoses included, but were not limited to, depressive disorder and aphasia. Resident #29 had a current,8/18/11, quarterly, Minimum Data Set assessment which indicated the resident had cognitive impairment and required cueing and prompting for decision making. Resident #29 had a current, 8/11, care plan problem regarding nutritional risk. An approach to this problem was to provide a diet as ordered. 7.) During the 9/12/11 5:20 p.m. to 6:30 p.m., main dinning room supper meal observation the following concerns were noted: a.) CNA #8 was feeding both Resident #69 and Resident #25. The two residents were seated at the same table. Resident #25 was seated in a manner that he could see the back of Resident #69's chair. The style of wheelchair was such that CNA #8 could not sit and reach both residents for feeding assistance. CNA #8 moved back and forth between Residents #25 and #69 throughout the meal. During this process, Residents #25 and #69 sat for multiple			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	periods of 3 to 7 minutes without being offered any food or interaction as CNA #8 moved to another seat to feed the other resident. b.) CNA #7 was feeding both Resident #63 and #70. These two residents were seated at different tables. Throughout the meal CNA #7 moved from table to table to feed the two residents. During this process, Residents #63 and #70 sat for multiple periods of 3 to 7 minutes without being offered any food or interaction as CNA #7 moved to another table to feed the other resident. At 6:30 p.m., after Resident #63's meal had sat in front of her for greater than 30 minutes with only being offered a very small portion of her supper, the Food Services Supervisor took the temperature of Resident #63's food items. Resident #63 had pureed BBQ ribblets, mashed potatoes and pureed green beans. All three hot food items tested at 85 degrees to 82 degrees. c.) Dependent Residents #29 and #67 were assisted to their tables by staff members by 5:30 p.m. Resident #29 sat quietly at her table without food as her tablemate ate her meal. Resident #67 sat at his table alone drinking fluids and watching others eat. Both residents were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	told multiple times throughout the meal that their food items were on the way. During a 9/12/11, 6:20 p.m., interview Cook #9 indicated she had served all the meals to the main dinning room. Residents #29 and #67 had still not been served a meal tray. During an interview at 6:20 p.m., when informed of this concern, the Director of Nursing indicated the problem would be corrected and the residents were then served a meal. 8.) During a 9/12/11, 6:10 p.m., interview CNA #8 indicated this was the regular method and technique for feeding residents supper. During a 9/12/11, 6:11 p.m., interview CNA #7 indicated this feeding method was used when no additional staff came to assist with feeding. 9.) Review of an current, undated, facility form titled "Dining Room Facilitators Responsibilities", which was provided by the Administrator on 9/14/11 at 10:00 a.m., indicated the following: "Ensure all residents in dining area receive meal trays. Ensure that if a residents requires assistance, meal is not served until assistance is available."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10. On 9/12/11 from 11:50 a.m. to 12:10 p.m., Resident #13's incontinent care was observed. The resident indicated she needed to be changed as she had not been able "to hold it." Physical Therapist (PT) #3 transferred Resident #13 from her wheelchair (w/c) to the toilet and removed her pants and brief. The resident's brief was saturated with urine and had a small amount of dark brown bowel movement in this same brief. The resident's left upper outside pant leg was observed wet. After the resident had voided a small amount on the toilet, she indicated she was finished. PT #3 proceeded to put a new brief and a clean pair of pants on the resident before she transferred her back to the w/c. No incontinent care was observed completed as the resident was taken to the dining room for lunch by a visitor, who had just arrived. At this same time during an interview, PT #3 indicated she should have cleansed the resident prior to putting her new brief and pants on. On 9/13/11 at 4:00 p.m. during an interview, Resident #13 indicated when she had been taken to the bathroom on 9/12/11 before lunch, she would have liked to had been cleaned up before she was redressed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #13's record was reviewed on 9/13/11 at 2:35 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus, anxiety, and depression. The admission minimum data set assessment, dated 6/22/11, indicated the resident needed supervision and cueing in new situations. The resident required limited assist of 1 person for transfers and toileting. The resident was occasionally incontinent of bladder. 3.1-3(t)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation, and interview, the facility failed to ensure the resident's plan of care was followed for the application of Thrombo-embolic Deterrent hose (TED), and the discontinuation of a medication for 2 of 13 records reviewed for following the plan of care in a sample of 21. (Resident # 96 & # 84) Findings include: 1. The record for Resident # 96 was reviewed on 9/13/11 at 9 a.m. Current diagnoses included, but were not	F0282	A. Resident #96 physician was notified of the need to discontinue Ambien.Orders recieved and medication was discontinued. Family notified of order. Care Plan reviewed and revised as appropriateResident #84 was assessed and order recieved to discontinue Ted Hose.Family notified of order change. Care plan reviewed and revised as appropriate.B. Residents will be identified using the admission process, scheduled care plan meetings and the ongoing 24-hour assessment process.A comprehensive facility wide audit was completed for active residents to determine that physician orders had been	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, depression and Alzheimer's Disease. Current physician orders indicated an order for ambien 5 milligrams (sedative) to be given at bedtime. Original date of order was 9/9/10. A physician progress note dated 7/22/11 indicated the resident had a history of insomnia and had been on ambien 5 milligrams since September of 2010. The note indicated to discontinue the ambien due to the resident was well controlled. The July, August, and September Medication Administration Record (MAR) for 2011 indicated the resident continued to receive the ambien daily. On 7/13/11 at 5:15 p.m., the Director of Nursing indicated the ambien had not been discontinued on 7/22/11 but was discontinued today. 2. The record for Resident # 84 was reviewed on 9/12/11 at 12:30 p.m. Current physician orders for September 2011 indicated an order for TED hose to be worn daily. Original date of the order was 6/14/10. On 9/12/11 at 11:20 a.m., the resident was		reviewed for the past 90 days and orders had been taken off and transcribed correctly. Particular attention was paid to physician progress notes that may indicate any note of discontinuation ofmedications. Any identified areas were immediately corrected. A comprehensive facility wide audit was completed for active residents to detrmine that ted hose were applied as ordered. Those identified had appropriate applications.C. Licensed staff was educated on following physician orders. A list of residents seen by the nurse practioneer will be provided to the DNS after each visit.Those residents identified will be reviewed by the unit managers to determine that orders were taken off as orderedNew resident orders will be taken to scheduled clincal meeting for review.Direct care staff will be inserviced to notify licensed staff should residents refuse treatments.D. The DNS/Designee will perform the following audits:Review 12 residents records weekly times 6 months then 4 resident records weekly time 6 months to total 12 months of auditing, to determine orders were taken off correctly.Observational rounds will be completed 5 times weekly, to include all three shifts to determine that those residents with orders for ted hose are applied as ordered. Auditing will contineu for 12 mo. or until such	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in his wheelchair in the dining room with socks on. No TED hose were observed. On 9/12/11 at 5:30 p.m., the resident was in his wheelchair in the dining room with socks on. No TED hose were observed. On 9/13/11 at 7:30 a.m., the resident was in his wheelchair in the dining room, no TED hose were observed on the resident. On 9/14/11 at 7:55 a.m., the resident was in his wheelchair in the dining room, no TED hose were observed on the resident. At that time, the south unit manager indicated the TED hose had now been discontinued because the resident had refused to wear them. She indicated she was not aware the resident had refused and the CNAs have now been informed to notify her if a resident refuses to wear TED hose. 3.1-35(g)(2)		time as the facilities Performance Improvement committee during its monthly meeting recommends discontinuation of the monitoring. Additional education will be provided with any identified issues.E. 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observations, record review, and interview, the facility failed to ensure heel protectors were utilized to promote the healing of pressure areas on the resident's heels for 1 of 3 residents reviewed with pressure areas in a sample of 21. (Resident #5) Findings include: 1. On 9/12/11 from 2:45 p.m. to 2:50 p.m., Resident #5 was observed in her bed with her eyes closed. In preparation, CNA #1 uncovered the resident to check her. No heel protectors were observed on with the resident wearing socks. After CNA #1 completed her check for incontinence, she repositioned her. As she covered her up, no heel protectors were utilized. During interview on 9/12/11 at 4:45 p.m., CNA #4 indicated the resident had refused to get up for dinner and remained in bed presently. No heel protectors were on.	F0314	A. Residnt #5 was assessed. Physician visit was made. Orders reviewed. Care PLan reviewed and revised. Heel Protectors applied. Direct care staff for resident #5 on 9-12-2011 and 9-13-2011 was educated by teachable moment regarding the application of heel boots per resident's plan of care and following physician orders.B. Residents will be identified using the admission and 24-hour assessment process. Facility SKin Sweep was completed by the unit managers to identify any other resident with orders for preventative devices that may have been affected. No other residents were affected.A comprehensive facility wide audit was completed for active residents to determine that preventative measures were in place and utilized as prescribed.C. Nursing staff was educated on the requirement of F 314 regarding prevention of pressure areas and pressure reducing measures.Nursing staff will also continue to participate in ongoing educational training and	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 9/12/11 at 5:35 p.m., Resident #5 was observed being fed by CNA #1. No heel protectors were on as the resident was resting on her back with the head of bed elevated. On 9/13/11 at 8:50 a.m., Resident #5 was observed up in her wheelchair in her room with no heel protectors on. During interview on 9/13/11 at 9:00 a.m., CNA #4 indicated she did not use the heel protectors when the resident was in her bed. On 9/13/11 at 9:15 a.m., Resident #5's heels were observed while awaiting the nurse for the dressing change to the coccyx. The right heel was observed a quarter-sized. irregular shaped, black scabbed area on the bottom with slight redness observed around the black area. The left heel had an irregular, almost quarter-sized red to pink area on the bottom. The left heel was also observed with dry, scaly white skin on the bottom of the heel. As CNA #4 checked blanching on the left heel, the resident was heard to say complain of discomfort. On 9/13/11 at 9:40 a.m., LPN #6 was observed to reposition the resident in her bed and indicated she was finished. No heel protectors were observed on the		preventative measures.D. Weekly skin prevention audits will be completed on 12 residents for 6 months, then 6 residents for 6 months to total 12 months of auditing by the DNS/Designee to determine that pressure prevention practices are utilized as prescribed.Auditing will include all shifts.The DNS/Designee will review the 24-hour report and new orders recieved over the last 24 hours related to pressure prevention and review them at morning clinical stand up meeting.Any issues identified will be immediately addressed and reported to the monthly Performance Improvement meeting to determine continued substantial compliance.E. 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

resident in her bed.

2. Resident #5's record was reviewed on 9/12/11 at 3:25 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, cardimyopathy, and bacteremia. The admission minimum data set assessment, dated 8/29/11, indicated the resident was unable to make her own decisions. She required extensive assistance of 1 person for activities of daily living. The resident did have a stage III pressure area.

The physician order, dated 8/22/11, was heel protectors on at all times and may remove for cleaning/bathing.

The "Initial Wound Visit / Re-evaluation" record indicated the right heel was dark green and measured 4.0 centimeters (cm) by 3.0 cm. and was described as unopened. The left heel measured 3.0 cm by 3.0 cm and described as a dark, unopened area.

The "Wound Progress Note/Reassessment" record indicated the following:

On 8/25/11, the right heel measured 3.5 cm (length) by 3.5 cm (width) by 0 depth; the left heel measured 3.0 by 3.0 by 0; the stage of both heels was indicated as deep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tissue injury (DTI); On 9/01/11, the right heel measured 3.0 by 1.8 by 0; the left heel measured 1.0 by 1.5 by 0; the stage of both heels was indicated as DTI; On 9/08/11, the right heel measured 3.0 by 1.7 by 0 and was indicated as unstageable; the left heel measured 1.0 by 1.0 by 0.1 and was indicated as DTI. 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, record review, and interview, the facility failed to ensure assessment and evaluation of a non-compliant resident with a previous clip alarm and to ensure a clip alarm being utilized was clipped to the resident to maintain the safety of the resident in the prevention of falls and injuries for 1 of 5 residents reviewed for falls in a sample of 21. (Resident #13) Findings include: On 9/12/11 from 9:40 a.m. to 10:10 a.m. during initial tour, Resident #13 was observed in her wheelchair (w/c) with her	F0323	A. Resident #13 no longer resident within the facility.Therapy was inserviced on re-application of alarms following services provided for resident safety.C.N.A assignment sheets updated to reflect those residents with alarms.Residents with alarms had their orders and care plans reviewed for accuracy.B Upon review there were no other residents identified to have been affected. Residents will continue to be identified using the 24 hour admission assessment process and significant change process.C. Facility staff was in-serviced on supervision and accident prevention related to monitoring alarm use and application as ordered.C.N.A	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	eyes closed. Her clip alarm was observed unclipped. At this same time during an interview, Unit Manager #2 indicated the resident was a fall risk and was non-compliant at times. The resident's alarm was then clipped to her top. On 9/12/11 from 11:50 a.m. to 12:10 p.m., Resident #13's personal care was observed. In preparation Physical Therapist (PT) #3 unclipped the resident's alarm and took the resident to the bathroom. After completing this care, the resident was taken by her w/c to the dining room with her personal clip alarm left unclipped. In the dining room, CNA #4 was informed the resident's personal clip alarm was not clipped to the resident. CNA #4 indicated she would clip the alarm back on the resident for her safety. On 9/12/11 at 2:25 p.m. and at 2:55 p.m., Resident #13 was observed sitting on the side of the bed with no alarm observed. On 9/12/11 at 2:55 p.m. after checking Resident #13's bed, CNA #1 indicated the resident did not have an alarm on. At this same time during an interview, CNA #1 indicated she had checked with the nurse and the resident was to have a pull tab (clip) alarm on her w/c and the bed. CNA #1 then placed the clip alarm from the resident's w/c to her for the bed alarm.		assignment sheets are reviewed daily to reflect those residents that require alarms, and updated as changes occur.Therapy staff was additionally educated on the re-application of alarms post therapy.D. The monitoring of thisplan of correction will be the joint effort between the Executive Director/ DNS and Unit Managers. Observational Audits will be conducted on appropriate application of alarms 3 times weekly for 6 months then random weekly observations for 6 months to total 12 months of audits. Any deviation from this practice will immediately be addressed and corrected.Results of these findings will be presented at the monthly Performance Improvement meeting and until such time substantial compliance is achieved and the committee recommends the findings no longer need reported.E 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

On 9/12/11 at 5:45 p.m. Resident #13 was observed sitting on the side of the bed eating her dinner. Her clip alarm was observed not clipped to her. CNA #5 was notified and clipped the alarm to the resident as she finished eating her dinner.

On 9/13/11 at 8:50 a.m., Resident #13 was observed sleeping in her bed with no alarm observed. On this same day at 9:45 a.m., the resident was observed still sleeping in her bed with the clip alarm on.

On 9/15/11 at 8:30 a.m. during an interview, Unit Manager #10 indicated a resident would be given a sensor to the bed and a tab to the chair for 72 hours after admission for fall prevention. If the resident was not considered to be safe, another intervention could be added if needed depending on the circumstances, for example, if the resident had fallen out of bed, the bed could be lowered.

On 9/15/11 at 1:20 p.m. during an interview, Unit Manager #10 indicated although the resident had been non-compliant previously, she used the pull tab alarm again.

Resident #13's record was reviewed on 9/13/11 at 2:35 p.m. The resident's diagnoses included, but were not limited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to, diabetic mellitus, anxiety,chronic airway obstruction, ischemic heart disease, and depression. The admission minimum data set assessment, dated 6/22/11, indicated the resident needed supervision and cueing in new situations. The resident required limited assist of 1 person for transfers and toileting. There was no information related to falls before the resident's admission to the facility. The physician order, dated 6/28/2011, was pull tab alarm to w/c and bed and check placement and function every shift. The "Morse Fall Risk Scale," dated 6/14/11, indicated a total score of 40 with a score of 25 to 44 indicated a medium risk for falls. The "RESIDENT PROGRESS NOTES," indicated the following: On 6/22/11 at 7:30 p.m., the resident was noted to be disconnecting her tab alarm. On 6/23/11 at 8:00 p.m., the "bed sensor/pull tab" alarms were discontinued due to the resident's non-compliance. On 6/28/11 at 1:00 a.m., the resident was found on her hands and knees beside the bed with no injury noted. The "POST FALL EVALUATION," dated 6/28/11 at 1:00 a.m., indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was found beside her bed on her hands and knees and did not remember what had happened before the fall. No injuries were indicated. She did indicate she had been sitting on her bed. A pull tab alarm was initiated. The summary of the Interdisciplinary Team was to initiate the pull tab alarm again to alert staff when the resident was rising. The 'SKILLED CARE SUMMARY," dated 6/28/11, indicated the resident had a fall on 6/28/11 when she had slid out of bed. The "RESIDENT EVENT RESPONSE" policy was provided by the Director of Nursing on 9/14/11 at 9:30 a.m. This current policy indicated the following: "...Procedure ...2. Assess the resident's risk for future events of the same nature ...4. Determine root cause(s) of the event...." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.			
	Based on observation, interview and record review, the facility failed to ensure residents were served meals in order to maintain stable weights and healthy nutritional parameters for 2 of 21 residents reviewed for service of meals and nutrition (Residents #29 and #67). Findings include: 1.) Resident #67's clinical record was reviewed on 9/14/11 at 10:50 a.m. Resident #67's current diagnoses included, but were not limited to, schizophrenia and hypertension. Resident #67 had a current,7/1/11, quarterly, Minimum Data Set assessment which indicated the resident rarely or never made decisions. Resident #67 had a current, 7/11, care	F0325	A. Resident's #67 and #29 were assessed and assistance was provided to encourage meal intake. Care plans were reviewed and revised as appropriate.Direct care staff was in-serviced on providing assistance with dining in a manner that provides dignity, nutrition and social interaction.Cook #9 was immediately inserviced on dining procedures. Licensed staff will notify dietary when dining room residents have all been served to ensure that assistance is provided to those residents that require it.B. Any residents that require assistance with feeding had the potential to be affected; however no negative outcome was identified.C. Direct care staff was in-serviced on providing assistance with dining in a manner that provided dignity, nutrition and social interaction.Dietary staff was in-serviced on dining room procedures.Management supervison/Dining Room Facilitator will be provided during all three meals to determine that assistance is provided to those	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan problem regarding nutritional risk. An approach to this problem was to provide a diet as ordered. Resident #67 had a current 7/11 care plan problem which indicated the resident has "incoherent speech, resident often will not be able to make full sentence or will not ask question coherently." 2.) Resident #29's clinical record was reviewed on 9/14/11 at 9:30 a.m. Resident #29's current diagnoses included, but were not limited to, depressive disorder and aphasia. Resident #29 had a current,8/18/11, quarterly, Minimum Data Set assessment which indicated the resident had cognitive impairment and required cueing and prompting for decision making. Resident #29 had a current, 8/11, care plan problem regarding nutritional risk. An approach to this problem was to provide a diet as ordered. 3.) During the 9/12/11 5:20 p.m. to 6:30 p.m., main dinning room supper meal observation the following concerns were noted: Dependent Residents #29 and #67 were		residents that require it.D. The monitoring of this tag will be the joint effort of the Executive Director/DNS/Designee.Executive Director/Designee will randomly audit one meal five times weekly for dining room service.Audits will continue for six months then decrease to three meals for six months to total twelve months of auditing. Results of auditing will be taken to the monthly Performance Improvement Management meeting until substantial compliance is achieved and or the committee recommends discontinuation of monthly reporting.E. 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assisted to their tables by staff members by 5:30 p.m. Resident #29 sat quietly at her table without food as her tablemate ate her meal. Resident #67 sat at his table alone drinking fluids and watching others eat. Both residents were told multiple times throughout the meal that their food items were on the way. During a 9/12/11, 6:20 p.m., interview Cook #9 indicated she had served all the meals to the main dinning room. Residents #29 and #67 had still not been served a meal tray. During an interview at 6:20 p.m., when informed of this concern, the Director of Nursing indicated the problem would be corrected and the residents were then served a meal. 4.) Review of an current, undated, facility form titled "Dining Room Facilitators Responsibilities", which was provided by the Administrator on 9/14/11 at 10:00 a.m., indicated the following: "Ensure all residents in dining area receive meal trays. Ensure that if a residents requires assistance, meal is not served until assistance is available." 3.1-46(a)(1) 3.1-46(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observations and interview, the facility failed to ensure staffing was posted in a timely manner and included the required information related to total hours worked for 4 of 4 days of the survey. This deficiency had the potential to impact 101 of 101 residents and visitors.	F0356	A. The nature of the Deficiency prohibits the identification of affected residents.B. The nature of the Deficiency prohibits the identification of affected residents.C. The staffing coordinator will post staffing data on a daily basis prior to the beginning of each shift.Posting will reflect census, total number	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(September 12, 13, 14, and 15, 2011) Findings include: On 9/12/11 at 9:35 a.m., no staffing was observed posted. On this same day at 2:05 p.m., staffing was observed posted for 9/12/11. The staffing posted indicated the following: Days: 1 RN and 2 LPN's worked from 8 a.m. to 4:30 p.m.; 3 RN's and 1 LPN worked 6:30 a.m. to 3 p.m.; 1 LPN worked from 10:30 a.m. to 6:30 p.m.; 11 CNA's worked form 6 a.m. to 2 p.m. and 1 CNA worked from 8 to 4:30 p.m.; the licensed staff total was 8, and the non-licensed staff was 12. Eves: 3 RN's and 2 LPN's worked 2:30 p.m. to 11 p.m.; 1 LPN worked 2:30 p.m. to 6:30 p.m.; 9 CNA's worked 2 p.m. to 10 p.m.; Nights: 4 LPN's worked 10:30 p.m. to 7 a.m.; 4 CNA's worked 10 p.m. to 6 a.m. No actual total hours were indicated for any category. On 9/13/11 at 8:05 a.m., the staffing posted was for 9/12/11. On 9/14/11 at 7:35 a.m., the staffing posted was for 9/13/11 with similar information as 9/12/11.		and the actual hours worked by direct care staff.The facility will maintain the posted daily nurse staffing data for a minimum of 18 months.Staffing Development Coordinator in-serviced Staffing Coordinator on the requirements of F356D. The responsible person for the overall compliance will be the Director of Nursing.Audits will consist of daily observation of Nurse Staffing information for 6 months to total 12 months of auditing.Results of audits will be taken to the monthly Performance Improvement meeting to determine continued compliance and or until the committee recommends discontinuation of monitoring.E 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 9/15/11 at 7:45 a.m., the staffing posted was for 9/14/11 with similar information as 9/12/11. During interview on 9/15/11 at 9:22 a.m., the Staffing Coordinator indicated she would wait until morning meeting to obtain the resident census. She indicated she would then use her schedule to determine the number of licensed and non-licensed staff personnel. Next, she would indicate the number of personnel for each shift as the actual hours work. She indicated she was not aware she was to total the hours worked or to have the staffing posted prior to the start of the shift. She also indicated she was to keep the staffing records for 15 months. 3.1-13(a)			
F0372 SS=C	The facility must dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to ensure refuge was contained in a covered container for 1 of 2 observations. This deficiency had the potential to impact 101 of 101 residents. (September 13 and 15, 2011) Findings include: On 9/13/11 at 11:30 a.m. during the	F0372	A. The dumpster lid was closed and surrounding area was cleaned.B. The nature of the deficiency prohibits the identification of affected residents.C. The Executive Director or designee will check the dumpster lid for closure and surrounding area on a daily basis to ensure cleanliness.Any identified areas of concern will be immediately addressed and	10/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	environmental tour with the Maintenance Supervisor, the outside dumpster was observed. Two large dumpsters were observed in a fenced area. One of the dumpsters was observed with both lids opened and pinned behind the dumpster. Also, trash bags were observed piled to the top with 2 trash bags on the ground behind this same dumpster. At this same time during an interview, the Maintenance Supervisor indicated he was unable to close the dumpster lid due to when the dumpster was emptied, the dumpster was put back with the lids pinned behind it, which happened frequently. He also indicated he was unable to pull the large-sized dumpsters forward to retrieve the lids and close the dumpster. The second dumpster was observed covered and was not full. On 9/13/11 at 2:50 p.m., the Maintenance Supervisor indicated the dumpsters were emptied 3 times a week (Monday - Wednesday - Friday). On 9/15/11 at 9:10 a.m. with the Director of Environmental Services, the 2 dumpsters were observed with their lids on. At this same time during an interview, she indicated at least 3 to 4 times a month the dumpster's lids were pinned behind the dumpsters. This resulted in the dumpsters being left open		corrected.The Staff Development Coordinator will in-service the facility staff on the importance of keeping the dumpster lid closed and surrounding area clean.D. The Executive Director or designee, will monitor through direct observation the closure of the dumpster lid and surrounding area for cleanliness, at least 3 times weekly for 6 months, then weekly random observations for 6 months to total 12 months of auditing to determine that the waste is properly contained inside the dumpster.The Executive Director is responsible for overall compliance.Results of the audits will be taken monthly to Performance Improvement meeting until continued compliance is achieved and or the committee recommends discontinuation of monitoring.E. 10-15-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	until the next pick up time. 3.1-21(i)(5)			